4. PROGRAM REGULATIONS

4. PROGRAM REGULATIONS (cont.)

420.401: Introduction

(A) 130 CMR 420.000 contains regulations governing dental services under MassHealth. All dental providers participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations at 130 CMR 420.000 and 450.000.

(B) In general, and as further described below, coverage of dental services varies for
(1) members under age 21;
(2) members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D); and
(3) all other members aged 21 and older.

(C) Coverage for members under age 21 includes services essential for the prevention and control of dental diseases and the maintenance of oral health. Coverage for members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D) is similar, but not identical, to coverage for members under age 21. Coverage for all other members aged 21 and older includes emergency care, exodontic services, oral surgery, and some X-ray services.

(D) The service descriptions and limitations applicable to each group are set forth in the regulations that follow. Where noted, certain service descriptions are the same for all members, regardless of age or circumstances.

420.402: Definitions

The following terms used in 130 CMR 420.000 have the meanings given in 130 CMR 420.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 420.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 420.000 and in 130 CMR 450.000.

Controlled Substance – a drug listed in Schedules II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A"-rated) by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the Division. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 420.418(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 420.000.

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

Pharmacy On-Line Processing System (POPS) – the on-line, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Unit-Dose Distribution System – a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

420.403: Eligible Members

(A) (1) MassHealth Members. The Division pays for dental services provided to MassHealth members, subject to the restrictions and limitations described in the Division's regulations. 130 CMR 450.105 specifically states for each MassHealth coverage type, which services are covered and the members eligible to receive those services.
(2) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

420.404: Provider Eligibility: Participating Providers

The Division makes payment for services described in 130 CMR 420.000 only to providers of dental services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to dental services under MassHealth. In order to claim payment, the participating provider must be the dentist who actually performed the service.

(A) A dentist who is a member of a group practice can direct payment to the group practice under the provisions of the Division's regulations governing billing intermediaries in 130 CMR 450.000. The dentist furnishing the services must be enrolled as an individual provider, and must be identified on claims for his or her services.

(B) A dental school may claim payment for services provided in its dental clinic.

(C) A community health center, hospital-licensed health center, managed care organization, or hospital outpatient department may claim payment for services provided in its dental clinic.

(D) A dental laboratory may claim payment for prosthetic material delivered to a dentist provided that the material was not otherwise provided or paid for by the dentist.

420.405: Provider Eligibility

(A) In-State Providers. The following requirements apply when the dental provider is located in Massachusetts.

(1) Practitioner. A dentist engaged in private practice is eligible to participate in MassHealth if licensed to practice by the Massachusetts Board of Registration in Dentistry. Private practices may include, but are not restricted to, solo, partnership, or group practices.

(2) Managed Care Organization. A managed care organization with a dental clinic is eligible to participate in MassHealth as a provider of dental services.

(3) Community Health Center. A licensed community health center is eligible to participate in MassHealth as a provider of dental services.

(4) Dental School. A teaching clinic of a dental school accredited by the American Dental Association is eligible to participate in MassHealth as a provider of dental services.

(5) Dental Laboratory. When a dentist's salary from a hospital, state institution, or nursing facility includes compensation for professional services furnished to members in that facility, a dental laboratory is eligible to be a provider and to be paid for the prosthetic materials supplied to a dentist where such materials are not otherwise provided or paid for by the dentist.

(6) Hospital Outpatient Department and Hospital-Licensed Health Center. Dental services provided to members in a hospital outpatient department's dental clinic or a hospital-licensed health center are paid for in accordance with the hospital's signed provider agreement with the Division.

(7) Other Dental Clinic. A dental clinic must be licensed by the Massachusetts Department of Public Health to be eligible to participate in MassHealth. A dental clinic that limits its services to education and diagnostic screening is not eligible to participate.

(8) Specialist in Orthodontics. A dentist is a specialist in orthodontics if the dentist has completed a minimum of two years' training in an accredited postgraduate program leading to board eligibility or board certification as a Diplomate of the American Board of Orthodontists.

(9) Specialist in Oral Surgery. A dentist is a specialist in oral surgery if the dentist has completed a minimum of three years' training in an accredited oral and maxillofacial surgical program leading to board eligibility or certification in oral and maxillofacial surgery as prescribed by the American Board of Oral and Maxillofacial Surgery. An oral surgeon who is also a licensed medical doctor must bill in accordance with the regulations in 130 CMR 420.000 governing the dental program.

(B) Out-of-State Providers. A dental provider located outside of Massachusetts is eligible to be a participating provider in MassHealth and to be paid for dental services provided to MassHealth members only if the provider is licensed or certified by the state in which the provider practices, the provider meets the specific provider eligibility requirements listed in 130 CMR 420.404, and the provider meets the conditions set forth in 130 CMR 450.109.

(130 CMR 420.406 Reserved)

420.407: Maximum Allowable Fees

(A) Introduction. The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all dental services purchased by government agencies. DHCFP publishes a comprehensive listing of dental services and rates. The Division pays for a limited number of the services listed by DHCFP. Refer to Subchapter 6 of the *Dental Manual* for the Division's list of covered services. Payment is always subject to the conditions, exclusions, and limitations set forth in the regulations in 130 CMR 420.000. Payment for a service will be the lower of the following:

(1) the provider's usual charge to the general public for the same or a similar service; or

(2) the maximum allowable fee listed in the applicable DHCFP fee schedule.

(B) Services for Members Under the Age of 21 and for Members Aged 21 and Older. The scope of reimbursable dental services is more extensive for members under the age of 21, and for members aged 21 and older who have special circumstances that meet the criteria for prior authorization set forth in 130 CMR 420.410(D) than for other members aged 21 and older. If the service is reimbursable only for members under the age of 21, or for a more restricted age group, that is noted in the service description in 130 CMR 420.000.

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420.408: Noncovered Services

The Division does not cover the following dental services:

(A) cosmetic services;

(B) overdentures and their attachments;

(C) implants of any type or description;

(D) counseling or member-education sessions;

(E) unilateral partials;

(F) laminate veneers;

(G) tooth splinting for periodontal purposes;

(H) medical or dental treatment of temporomandibular joint (TMJ) disease;

(I) habit-breaking appliances;

(J) night guards and orthotic splints, including mandibular orthopedic repositioning appliances (MORAs);

(K) ridge augmentations;

(L) grafts of any nature;

(M) root canals filled by silver point technique, or paste only;

(N) oral-hygiene devices and appliances, dentifrices, and mouth rinses;

(O) procedures and techniques that are considered unproven or experimental, or are not approved by the American Dental Association and its related certifying specialty boards as currently accepted dental practice (for example, genioplasties and facial bone augmentations);

(P) other specialized techniques and associated procedures; and

(Q) all other procedures and services not listed in the *Dental Manual*.

420.409: Noncovered Circumstances

(A) Conditions. The Division does not pay providers for dental services under any of the following conditions:

(1) the services are provided in a state institution by a state-employed dentist or a dental consultant;

(2) the services are furnished by a provider whose salary includes compensation for professional services;

(3) under comparable circumstances, the provider does not customarily bill private members who do not have health insurance; or

(4) the member is not an eligible MassHealth member on the date of service. The provider must verify the member's eligibility for MassHealth on the date of service even if the provider has obtained prior authorization for the service.

(B) Substitutions.

(1) If a member desires a noncovered substitute for, or a modification of, a covered item, the member must pay for the entire cost of the service. The Division does not pay for any portion of the cost of a noncovered service. In all such instances, before performing noncovered services, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for noncovered services.

(2) It is unlawful (M.G.L. c. 6A, § 35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of covered services, it will be the responsibility of the provider to prove that the member was offered a covered service, refused it, and chose instead to accept and pay for a noncovered service.

420.410: Prior Authorization

(A) Introduction.

(1) In order for certain services (listed in 130 CMR 420.410(C) and (D)) to be payable, the Division requires that the provider obtain prior authorization. The Division pays for these services, which are designated in Subchapter 6 and Appendix E of the *Dental Manual* with the abbreviation "P.A.," only when the provider has obtained prior authorization from the Division. The provider must not begin to furnish the service, except as provided under 130 CMR 420.410(A)(2), until the provider has requested and received written prior authorization from the Division. A prior-authorization request must present the total treatment plan in detail.

(2) The Division may grant prior authorization after a procedure has begun if, in the judgment of the Division, this treatment is medically necessary. When such a prior-authorization request is made, the provider must provide a written justification that the treatment will:

(a) alleviate suffering of the member;

(b) address a dental emergency; or

(c) involve an extenuating circumstance that must be detailed by the dentist.

(3) Requests for prior authorization must be submitted according to the instructions in Subchapter 5 of the *Dental Manual*.

(4) The Division reviews prior-authorization requests with consideration, where applicable, for whether the restoration work requested involves teeth that will be retained for many years and are critical to the member's long-term oral health.
(5) The Division does not consider prior-authorization requests for noncovered services for members aged 21 and older (see 130 CMR 420.408 and service limitations described throughout 130 CMR 420.000.).

(B) Other Requirements for Payment.
(1) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health-insurance payment.
(2) The Division will not pay for a prior-authorized service when the member's MassHealth eligibility is terminated on or before the date of service or a date adjudicated by the Division.
(3) When the member's MassHealth eligibility is terminated prior to delivery of a special-order good, such as a denture, the provider may claim payment in accordance with the provisions of 130 CMR 450.231(B). Refer to 130 CMR 450.231(B) for special procedures in documenting member eligibility for special-order goods.

(C) Services Requiring Prior Authorization.
(1) Services requiring prior authorization include, but are not limited to, the following:
(a) deep scaling and curettage;
(b) gingivectomy or gingivoplasty;
(c) mouth guard;
(d) interceptive orthodontic treatment visits;
(e) orthodontic treatment;
(f) diagnostic casts;
(g) diagnostic photographs;
(h) crowns, posts, cores, and fixed bridgework;
(i) endodontics (root canals and apicoectomies);
(j) prosthodontics (full, partial, and immediate dentures);
(k) rebase of complete upper or lower denture;
(l) reline of complete upper or lower denture;
(m) removal of impacted tooth (soft tissue, partial bony, or complete bony);
(n) surgical exposure of impacted tooth or unerupted tooth to aid eruption (for orthodontic purposes);
(o) vestibuloplasties (ridge extensions);
(p) excision of hyperplastic tissue, per arch;
(q) use of a hospital (inpatient or outpatient) or a freestanding ambulatory surgery center;
(r) certain surgical services performed in a hospital (for example, orthognathic surgery);
(s) additional fee for management of a physically or developmentally disabled member in the office;

(t) maxillofacial prosthetics;
(u) oral screenings of members undergoing radiation treatment, chemotherapy, or organ transplant; and
(v) any other service designated "P.A." in Subchapter 6 or Appendix E of the *Dental Manual*.

(2) The prescription of certain drugs requires prior authorization, as specified in 130 CMR 420.418.

(D) Prior Authorization for Diagnostic, Preventive, Restorative, Prosthodontic, and Endodontic Services for Members Aged 21 and Older. The Division pays for diagnostic, preventive, restorative, prosthodontic, and endodontic services (described in 130 CMR 420.432 through 130 CMR 420.439) for members aged 21 and older only when the provider has obtained prior authorization from the Division that the member meets the special circumstances criteria set forth in 130 CMR 420.410(D)(1).

(1) To demonstrate special circumstances, the member must have
(a) a severe, chronic disability that
(i) is attributable to a mental or physical impairment or combination of mental or physical impairments;
(ii) is likely to continue indefinitely; and
(iii) results in the member's inability to maintain oral hygiene; or
(b) a clinical condition (such as human immunodeficiency virus or cancer) that has advanced to a stage where an infection resulting from oral disease would likely be life-threatening.

(2) The provider's prior-authorization request must contain a clear, written statement signed by the member's physician or primary care clinician (on the clinician's letterhead) describing the member's disability or clinical condition, including but not limited to, the member's specific diagnosis and expected prognosis, and
(a) whether, and specifically why, the member's disability results in the member's inability to maintain oral hygiene; or
(b) whether the member's clinical condition has advanced to a stage where an infection resulting from oral disease would likely be life-threatening, including reference to specific supporting diagnostic evidence.

(3) For purposes of 130 CMR 420.410(D)(1)(a) and (2)(a), "inability to maintain oral hygiene" means that
(a) the member is unable to
(i) independently or with assistance (provided that such assistance actually is available), brush and floss his or her teeth and perform other routine acts of personal oral hygiene; or
(ii) report oral pain; or
(b) the nature of the member's disability is such that routine acts of personal oral hygiene are insufficient to effectively maintain such hygiene.

420.411: Pretreatment Review

Where the Division identifies an unusual pattern of practice of a given provider, the Division, at its discretion and pursuant to written notice, may require the provider to submit any proposed treatments identified by the Division, including those not otherwise subject to prior authorization, for the Division's review and approval prior to treatment.

420.412: Individual Consideration

(A) Certain services are designated "I.C." (indicating individual consideration) in Subchapter 6 and Appendix E of the *Dental Manual*. This means that a fee could not be established for these service codes. Service codes for unlisted or unspecified procedures are also designated as "I.C." The Division determines appropriate payment for individual-consideration services from the provider's detailed report of services furnished. The report must include a narrative summary or operative report, and laboratory, X-ray, and pathology reports. The Division does not pay claims for "I.C." services without a complete report. If the documentation is illegible or incomplete, the Division will deny the claim.

(B) Determination of the appropriate payment for an individual-consideration service is in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies; and
(5) any extenuating circumstances or complications.

420.413: Separate Procedures

Certain procedures are designated "S.P." in the service descriptions in Subchapter 6 and Appendix E of the *Dental Manual*. "S.P." is an abbreviation for separate procedure. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate procedure not immediately related to other services. (For example, the Division does not pay for a frenectomy when it is performed as part of a vestibuloplasty, and full-study models are not reimbursable separately when performed as part of orthodontic treatment or diagnosis; however, the Division does pay for full-study models separately when they are requested by the Division.) The administration of analgesia and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

420.414: Recordkeeping Requirements

Federal and state regulations require that all MassHealth providers maintain complete written records of patients who are members. All records, including X rays, must be kept for a minimum of four years after the date of service. Records for members who are residents of long-term-care facilities must be retained by the dentist as part of the member's dental record and by the nursing facility as part of the member's record at the facility. The fees for all dental services listed in 130 CMR 420.000 include payment for preparation of the member's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and necessity of care furnished to the member. Evidence must include examination results, diagnostic charting, description of treatment, X rays, and findings of other diagnostic tests. For all claims under review, the member's medical and dental records determine the appropriateness of services provided to members. The written dental record corresponding to the services claimed must include, but is not limited to, the following:

(A) the member's name, date of birth, and sex;

(B) the member's identification number;

(C) the date of each service;

(D) the name and title of the individual servicing provider furnishing each service, if the dental provider claiming payment is not a solo practitioner;

(E) pertinent findings on examination and in medical history;

(F) a description of any medications administered or prescribed and the dosage given or prescribed;

(G) a description of any anesthetic agent administered, the dosage given, and the anesthesia flowsheet;

(H) a complete identification of treatment, including, when applicable, the arch, quadrant, tooth number, and tooth surface;

(I) dated and mounted X rays, if applicable; and

(J) copies of all approved prior-authorization requests.

420.415: Report Requirements

(A) General Report. A general written report that includes a diagnosis and a description of the service performed must accompany the dentist's claim for payment when the service description in Subchapter 6 or Appendix E of the *Dental Manual* stipulates "with report only," when the service is designated "I.C.," or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable the Division to assess the extent and nature of services performed. The report can be on the claim form or on a separate piece of paper with the dentist's or hospital's letterhead. Supporting documentation, including pathology, admission, and operative reports, must be attached.

(B) Operative Report. For surgical procedures designated "I.C." and for any service that is an unlisted or unspecified procedure, an operative report must accompany the provider's claim. An operative report must contain the name of the surgical procedure, the name and date of birth of the member, the date of the service, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and of any assistant, and the technical procedures performed.

420.416: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. Legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 420.417(C) are covered only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the practitioner has no DEA registration number, the practitioner must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacy determines that an emergency exists, the Division will authorize a pharmacy to dispense at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations.

(C) Refills.
(1) The Division does not pay for prescription refills that exceed the specific number authorized by the prescriber.
(2) The Division pays for a maximum of five monthly refills.
(3) The Division pays for more than five refills within a six-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 420.416(D).
(4) The Division does not pay for any refill dispensed after six months from the date of the original prescription.
(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(D) Quantities.
(1) Days' Supply Limitations. The Division requires that all drugs be prescribed and dispensed in at least a 30-day supply, but no more than a 90-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 420.416(D)(2).

(2) Exceptions to Days' Supply Limitations. The Division allows exceptions to the limitations described in 130 CMR 420.416(D)(1) for the following products:

(a) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(b) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;

(c) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(d) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 90-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);

(e) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments); and

(f) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs).

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the provider. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The Division considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

420.417: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth.

(1) Legend Drugs. The Division pays only for legend drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8.

(2) Nonlegend Drugs. The Division pays only for the nonlegend drugs listed in Appendix I of the *Dental Manual* (Nonlegend Drug List).

(B) Medical Supplies. The Division pays only for the medical supplies listed below:

(1) blood and urine testing reagent strips used for the management of diabetes;

(2) disposable insulin syringe and needle units;

(3) insulin cartridge delivery devices and needles (for example, pens);

(4) lancets; and

(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers).

420.418: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The Division pays no more for a brand-name interchangeable drug product than its generic equivalent, unless:

(1) the prescriber has requested and received prior authorization from the Division for a nongeneric multiple-source drug (see 130 CMR 420.419); and

(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The Division does not pay for the following types of drugs or drug therapy.

(1) Cosmetic. The Division does not pay for legend or nonlegend preparations for cosmetic purposes or for hair growth.

(2) Cough and Cold. The Division does not pay for legend or nonlegend preparations that contain an antitussive or expectorant as a major ingredient, or any drug used solely for the symptomatic relief of coughs and colds, when they are dispensed to a noninstitutionalized member.

(3) Fertility. The Division does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The Division does not pay for any drug used for the treatment of obesity.

(5) Smoking Cessation. The Division does not pay for any drug used for smoking cessation.

(6) Less-Than-Effective Drugs. The Division does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(7) Experimental and Investigational Drugs. The Division does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(C) Service Limitations.

(1) The Division covers drugs that are not explicitly excluded under 130 CMR 420.418(B). The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.000. The MassHealth Drug List can be viewed on the Division's Web site, and copies may be obtained upon request. The Division will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. (See 130 CMR 450.303.)

(2) The Division does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs;

(c) drugs used for the treatment of male or female sexual dysfunction;

(d) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The Division, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993; and

(e) retinoids for members aged 26 or older. The Division pays for retinoids for members under age 26, and all other topical acne products for members of all ages who have cases of acne Grade II or higher, without prior authorization.

(3) The Division does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The Division does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the Division determines to be consistent with current medical evidence.

(D) Insurance Coverage.

(1) Managed Care Organizations. The Division does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(2) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the Division for the primary insurer's copayment for the primary carrier's preferred drug without regard to whether the Division generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 420.418(C)(2)(a), (c), (d), and (e). In such cases, the prescriber must obtain prior authorization from the Division in order for the pharmacy to bill the Division for the primary insurer's copayment.

420.419: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the Division for drugs identified by the Division in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 420.417(A)(1) and 420.418(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the Division for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Dental Manual*. If the Division approves the request, the Division will notify both the pharmacy and the member.

(C) The Division will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See U.S.C. 1396r-8(d)(5).) The Division acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

(E) The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.416 through 420.419. The Division will evaluation the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List.

420.420: Pharmacy Services: Member Copayments

Under certain conditions, the Division requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in the Division's administrative and billing regulations at 130 CMR 450.130.

420.421: Service Descriptions and Limitations: Introduction — Members Under Age 21

Service descriptions and limitations that are specific to members under age 21 are set forth in 130 CMR 420.422 through 420.429. Services that apply to all members, including members under age 21, are set forth in 130 CMR 420.452 through 420.457. In addition, services provided to members under age 21 must comply with all applicable requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services set forth in 130 CMR 450.140 through 450.149.

420.422: Service Descriptions and Limitations: Diagnostic Services — Members Under Age 21

The following service descriptions and limitations apply to preventive services provided to members under age 21.

(A) Comprehensive Oral Evaluation. A comprehensive oral evaluation by a dentist of a new member is reimbursable. A comprehensive oral evaluation is more thorough than a periodic oral evaluation, and is reimbursable only once per member for a dentist, dental group, or dental clinic. A comprehensive oral evaluation includes a written review of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, the diagnosis, and the preparation of treatment plans and reporting forms.

(B) Periodic Oral Evaluation. A periodic oral evaluation is reimbursable, only once per 12-month period, and no sooner than 12 months from the date of the most recent prior oral evaluation (whether periodic or comprehensive). For example, if the last evaluation was performed on February 20th, the next evaluation is reimbursable no sooner than February 20th of the following year. A periodic oral evaluation includes an update of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, the diagnosis, and the preparation of treatment plans and reporting forms. This service is not reimbursable on the same date of service as an emergency treatment visit and is not reimbursable if the visit results in a referral to a specialist.

(C) Emergency Dental Care. An emergency care visit is one that is intended to eliminate or alleviate acute pain or infection or both. Services that may be provided as part of an emergency care visit are those minimally required to address the immediate emergency and include, but are not limited to, diagnosis, draining of an abscess, or prescribing pain medication or antibiotics. The dentist must maintain in the member's dental records a diagnostic report of the treatment provided and must document the emergent nature of the care provided. No other services except X rays subject to limitations set forth in 130 CMR 420.423 and dental management of a physically or developmentally disabled member in the office (see 130 CMR 420.457) are reimbursable with a visit for emergency dental care. That is, if nonemergency treatment is provided during the same visit, the provider must bill for the nonemergency services, not for emergency dental care.

420.423: Service Descriptions and Limitations: X Rays — Members Under Age 21

The following service descriptions and limitations apply to X-ray services provided to members under age 21.

(A) Introduction. X rays must be taken as an integral part of diagnosis and treatment planning. The intent of limitations placed on X rays is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis. The provider must document efforts to obtain any previous X rays before prescribing more. X rays must be of good diagnostic quality and, when submitted to the Division, must be properly and securely mounted, dated, labeled for right and left views, and fully identified with the names of the dental provider and the member. When X rays submitted to the Division are not of good diagnostic quality, the provider may not claim payment for any retake X rays requested by the Division. Prior-authorization requests that are submitted with X rays that are not of good diagnostic quality will be deferred, pending submission of X rays that are of good diagnostic quality, or denied. X rays are considered to be of good diagnostic quality when they meet the following criteria:

(1) standard illumination permits differentiation between the various structures of the tooth, the periodontal ligament spacings, the supporting bone, and the normal anatomic landmarks;
(2) all crowns and roots, including apices, are fully depicted together with interproximal alveolar crests, contact areas, and surrounding bone regions; and
(3) images of all teeth and other structures are shown in proper relative size and contour with contiguous images, where anatomically possible.

(B) Intraoral X Rays.

(1) (a) Full-Mouth X Rays. Full-mouth X rays are reimbursable only for members 13 through 20 years of age and only once every three calendar years without prior authorization. Prior authorization is required for more frequent X rays. Full-mouth X rays must consist of either a minimum of 12 periapical X rays and two posterior bitewing X rays or a panoramic X ray plus two-to-four bitewing X rays. Full-mouth X rays must include all existing dentition and must be of good diagnostic quality as defined in 130 CMR 420.423(A). However, panoramic X rays cannot be substituted for X rays required for prior authorization. When the provider's total fee for individual periapical X rays (with or without bitewings) exceeds the Division's reimbursement for a full-mouth series, the provider may only claim reimbursement in an amount not to exceed the Division's reimbursement for a full-mouth series.

(b) Mixed Dentition: Series of 12 X Rays. A mixed-dentition series of X rays is reimbursable only for members aged six through 12. Such series must consist of 10 intraoral X rays and two posterior bitewing X rays. A panoramic X ray, two bitewing X rays, and necessary periapical X rays may be substituted for a mixed-dentition series. Mixed-dentition series of X rays are reimbursable only once every three calendar years without prior authorization. Prior authorization is required for more frequent X rays.

(2) Bitewing Survey. The Division pays for up to four bitewing X rays as separate procedures no more than twice per calendar year. Bitewing X rays may not be billed separately when taken as part of a full-mouth series. Prior authorization is required for more frequent X rays.

(3) Periapical X Rays. Periapical X rays may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the Division. A maximum of four periapical X rays are allowed per visit. Prior authorization is required for more frequent X rays.

(4) Edentulous Member. X rays are not required and are not reimbursable when the provider is requesting prior authorization for full dentures for an edentulous member.

(C) Panoramic X Rays. Panoramic X rays are not reimbursable for prosthodontics, endodontics, periodontics, and interproximal caries.

(1) Surgical Conditions. Panoramic X rays are reimbursable in conjunction with surgical conditions. Surgical conditions include, but are not limited to:

(a) impactions;

(b) teeth requiring extractions in more than one quadrant;

(c) large cysts or tumors that are not fully visualized by intraoral X rays or clinical examination;

(d) salivary-gland disease;

(e) maxillary-sinus disease;

(f) facial trauma; and

(g) trismus where an intraoral film placement is impossible.

(2) Nonsurgical Conditions.

(a) Panoramic X rays for nonsurgical purposes are reimbursable only for members under age 21. A panoramic X ray, two posterior bitewing X rays, and necessary periapical X rays may be substituted for a mixed dentition series and may be billed as a full-mouth series.

(b) The Division pays for only one panoramic X ray per member for nonsurgical conditions for members between the ages of six and 11 years to monitor the growth and development of permanent dentition.

(D) Diagnostic Photographic Prints.

(1) The Division accepts only photographic prints, not slides, to support prior-authorization requests for orthodontic treatment. In addition, the Division may request models. Seven photographic prints are required for prior authorization both for initial fabrication and insertion of the orthodontic appliance and for first-year orthodontic treatment visits as well as for prior-authorization requests for progress approval. If original photographic prints are not available, photographic prints of the models in the positions required in 130 CMR 420.423(D)(1)(a) through (c) are acceptable. The photographic prints must be a minimum size of three inches by three-and-one-half inches, mounted in clear plastic holders to allow viewing, and include the first molars. In addition, the photographic prints must include

(a) two photographic prints of the member's face (full face and side view);

(b) three photographic prints of teeth in occlusion (front and two side views); and

(c) two photographic prints of the occlusal mirror view of maxillary and mandibular teeth.

(2) Payment for photographic prints is included in the fees for orthodontic services. The Division will not pay for photographic prints as a separate procedure (see 130 CMR 420.413) when prior authorization is granted for orthodontic diagnosis or treatment. An orthodontic specialist must send diagnostic photographic prints to the Division as part of a prior-authorization request for orthodontic treatment. Those members who satisfy conditions for comprehensive orthodontic treatment may have treatment authorized. If such treatment is approved, the Division will grant prior authorization to the provider to bill the treatment. The fee for the orthodontic treatment includes reimbursement for orthodontic diagnosis and records, models, photographic prints, and X rays. However, if the treatment is denied based on the diagnostic photographic prints, the Division will grant prior authorization for the provider to obtain reimbursement for the photographic prints only.

(3) The Division may request diagnostic photographic prints for other prior-authorization services outlined in 130 CMR 420.000.

420.424: Service Descriptions and Limitations: Preventive Services —Members Under Age 21

The following service descriptions and limitations apply to preventive services provided to members under age 21.

(A) Prophylaxis. Prophylaxis is reimbursable only once per six-month period without prior authorization. For example, if the last prophylaxis was performed on February 10th, the next prophylaxis is reimbursable no sooner than August 10th of the same year. The Division may authorize this service up to one additional time per six-month period if, in the Division's opinion, the provider's description of the condition substantiates the need for additional prophylaxis (for example, if a mentally retarded or developmentally disabled individual with gingival disease has a limited ability for self-care). The prophylaxis must include a scaling of natural teeth, removal of acquired stains, and polishing of the teeth. As part of the prophylaxis, the practitioner must review with the member oral-hygiene methods including toothbrush instruction and flossing methods.

(B) Fluoride.

(1) Routine Topical Fluoride Treatment. Routine topical fluoride treatment is reimbursable only when provided no sooner than six months from the date of the most recent prior topical fluoride treatment. For example, if the most recent prior topical fluoride treatment was performed on August 3rd, the next topical fluoride treatment is reimbursable no sooner than February 3rd of the following year. Topical fluoride treatment immediately follows prophylaxis and consists of isolation and drying of the dentition by segments and continuous topical application of an approved fluoride agent for a suitable period. Treatment that incorporates fluoride with the polishing compound is considered to be part of prophylaxis and is not reimbursable as a separate procedure.

(2) Fluoride Supplements. The Division pays for fluoride supplements through the pharmacy program.

(C) Deep Scaling and Curettage. Deep scaling and curettage is a periodontal procedure that must be performed by a dentist and that is reimbursable, when indicated, once per quadrant every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical X rays for diagnosis, and a statement concerning the member's periodontal condition with the prior-authorization request. The Division does not pay for prophylaxis provided on the same day as deep scaling and curettage or on the same day as a gingivectomy or a gingivoplasty. The Division pays only for deep scaling and curettage of two quadrants on the same date of service in an office setting.

(D) Gingivectomies and Gingivoplasties. Gingivectomies and gingivoplasties are reimbursable only once every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical X rays for diagnosis, appropriate documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition with the prior-authorization request. The Division does not pay for a gingivectomy performed on the same day as a prophylaxis or deep scaling and curettage. The Division pays only for the gingivectomy or gingivoplasty of two quadrants on the same date of service in an office setting.

(E) Sealants. The Division pays for sealants only for members aged five through 20. Sealants are reimbursable only for permanent first and second noncarious molars that have deep developmental grooves. This service includes proper preparation of the enamel surface, etching, and placement and finishing of the sealant. This service is reimbursable only once every three years per tooth. The provider must replace sealants lost or damaged during the three-year period. The Division does not pay for restorations provided within one year after the placement of sealants.

(F) Mouth Guard. Only custom-fitted mouth guards are reimbursable and only when the provider has obtained prior authorization. The Division authorizes a mouth guard only if the member is engaged in an organized contact sport and only when the Division determines that the organization has no provision for the purchase of mouth guards for its participants. Mouth guards used as antibruxism devices for the treatment of temporomandibular joint disorders are not reimbursable.

420.425: Service Descriptions and Limitations: Restorative Services — Members Under Age 21

The following service descriptions and limitations apply to restorative services provided to members under age 21. The Division considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia, and polishing. The Division does not pay for restorations replaced within one year of the date of the completion of the original restoration.

(A) Amalgam Restorations.

(1) Cavity preparation must have an outline adequate for retention and extended to conform with the principles of prevention of recurrent caries.

(2) Payment will not be made for restorations attempted on primary teeth when early exfoliation (more than two-thirds of the root structure resorbed) is expected.

(3) Only one restoration per tooth surface per year is reimbursable. Occlusal surface restorations, including all occlusal pits and fissures, are reimbursable as a one-surface restoration whether or not the transverse ridge on an upper molar is left intact.

(4) The service code for a four-surface amalgam restoration is to be used for filling four or more surfaces. No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-surface amalgam restoration.

(B) Composite Resin Restorations.

(1) Composite restorations are reimbursable for all surfaces of anterior and posterior teeth.

(2) For anterior teeth, the Division pays no more than the maximum allowable amount for two two-surface composite restorations regardless of what other services are performed on the same tooth during the composite restoration treatment period and regardless of facial, lingual, or proximal approach.

(3) For a single posterior tooth, the Division pays no more than the maximum allowable amount for a three-surface composite restoration regardless of what other services are performed on the same tooth during the composite restoration treatment period. For posterior composites, the service code for a three-surface composite restoration must be used for filling three or more surfaces.

(4) Restoration of a fractured permanent anterior tooth with composite material and bonding or its equivalent is reimbursable when used instead of a full-crown restoration with loss of the incisal third of the crown. The fee for this service includes payment for the use of any pins. Prior authorization is required to perform this service on other than permanent anterior teeth.

(5) The fee for all composite resins includes payment for etch and bonding.

(6) Full-coverage composite crowns are reimbursable for anterior primary teeth.
(7) Preventive resin restorations are reimbursable only on occlusal surfaces and only as a single-surface posterior composite. Preventive resin restorations include instrumentation of the occlusal surfaces of grooves.

(C) Reinforcing Pins. Reinforcing pins are reimbursable only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. For teeth where four or more surfaces are restored, either commercial amalgam bonding systems or pins are reimbursable.

(D) Crowns, Posts, and Cores.
(1) Crowns, posts, and cores require prior authorization from the Division. For crowns, posts, and cores, the Division grants prior-authorization requests only when both the prognosis of the tooth and the condition of the remaining dentition is excellent, and then only when the Division determines that conventional restorations cannot be placed due to extensive loss of tooth structure, or when an amalgam or a composite restoration with pins will not withstand the forces of mastication. Acrylic jacket crowns (laboratory processed only) are reimbursable.
(2) The prior-authorization request must be justified by a sufficient number of peripical X rays of good diagnostic quality, dated and suitably mounted, to judge the general dental health. At a minimum, the request must be accompanied by a periapical X ray of the tooth and two posterior bitewing X rays. The Division reserves the right to request current full-mouth X rays or photographs, or both.
(3) Members are eligible for crowns, posts, and cores on permanent incisors, canines, bicuspids, and first molars only.
(4) If root-canal therapy is intended or has been performed previously, the Division grants prior-authorization requests for crowns, posts, and cores only if the loss of coronal tissue precludes a functional occlusion of the tooth. An X ray of the completed root-canal therapy on the tooth must accompany the request. Payment for progress X rays on root canals is included in the fee for root-canal therapy.
(5) Payment is not authorized for crowns provided solely for cosmetic reasons.
(6) When a provider treatment plan includes both root-canal therapy and a post and core with crown, the provider may submit to the Division either a single prior-authorization request for both procedures, or a separate prior-authorization request for each procedure. In either case, each prior-authorization request must contain sufficient information to support the medical need for the procedures requested. An X ray of successful root-canal therapy must be maintained in the member's record.
(7) The Division pays for stainless-steel or prefabricated resin crowns for primary molars or permanent molars. The Division pays for stainless-steel, prefabricated resin crowns for:
(a) primary incisors for members under age six; and
(b) primary canines for members under age nine.
Prior authorization is not required.
(8) Payment for crown repair does not require prior authorization by the Division except where the repair involves laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the Division for a request for prior authorization and individual consideration. The prior-authorization request must include X rays and documentation of estimated laboratory costs.

(E) Fixed Bridgework.

(1) Fixed bridgework requires prior authorization. The Division only grants prior-authorization requests for fixed bridgework for anterior teeth and only for members aged 16 through 20, with fully matured teeth. The member's oral health must be excellent and the prognosis for the life of the bridge and remaining dentition must be excellent.

(2) The provider must submit with the request for prior authorization X rays of good diagnostic quality, dated and suitably mounted.

(3) Payment for fixed bridgework repair does not require prior authorization by the Division except where the repair requires laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the Division a request for prior authorization and individual consideration for fixed bridgework repair. The prior-authorization request must include X rays and documentation of estimated laboratory costs.

420.426: Service Descriptions and Limitations: Endodontic Services — Members Under Age 21

The following service descriptions and limitations apply to endodontic services provided to members under age 21. The maximum allowable fee for endodontic services includes payment for all X rays performed during the same treatment session.

(A) Pulpotomy.

(1) A pulpotomy is reimbursable and consists of the complete removal of the coronal portion of the pulp to maintain the vitality of the tooth. It is limited to instances when the prognosis is favorable, and must not be applied to primary teeth that are mobile or that show advanced resorption of roots.

(2) For primary teeth, treatment is limited to cuspids and posterior teeth for members aged 10 or younger, and primary incisor teeth for members aged five or younger. Exceptions to these age limits require prior authorization.

(3) When provided in the same period of treatment, a pulpotomy is not reimbursable in conjunction with root-canal therapy.

(B) Root-Canal Therapy.

(1) Root canal therapy requires prior authorization. This service is limited to the permanent dentition and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition. Root-canal therapy on second or third molars is not reimbursable. Requests for prior authorization must include a total diagnosis and treatment plan supported by periapical X rays of all remaining teeth. These X rays must be of good diagnostic quality, dated and suitably mounted. The Division authorizes root-canal therapy only when the prior-authorization requirements for a crown (130 CMR 420.425(D)) are met. If the member will subsequently need a crown, the provider may either submit a single prior-authorization request for the combined post, core, crown, and root-canal treatment, or a separate prior-authorization request for each treatment procedure.

(2) The Division does not authorize payment for root-canal therapy if
(a) the prognosis of the involved tooth is poor;
(b) the involved tooth could be extracted and incorporated into an existing or allowable denture; or
(c) a total of three or more teeth will require root-canal therapy during the same period of treatment.
(3) Payment for root-canal therapy is limited to permanent incisors, canines, bicuspids, and first molars.
(4) All root canals must be properly prepared, shaped, and condensed to the apex.
(5) The maximum allowable fee for root-canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, vitality) tests; and pretreatment, treatment, and post-treatment X rays.
(6) An X ray of the completed root canal must be maintained in the member's record.

(C) Apicoectomy.
(1) An apicoectomy as a separate procedure requires prior authorization, and follows root-canal therapy when the canal is not to be reinstrumented. The request for prior authorization must substantiate valid evidence of the need for the service. The fee for the procedure includes payment for the retrograde filling and removal of pathological periapical tissue.
(2) The fee for an apicoectomy with root-canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment. This procedure requires prior authorization.
(3) The Division applies the criteria at 130 CMR 420.426(B) regarding root-canal therapy when evaluating prior-authorization requests for apicoectomies.

420.427: Service Descriptions and Limitations: Prosthodontic Services — Members Under Age 21

The following service descriptions and limitations apply to prosthodontic services provided to members under age 21.

(A) Dentures: General Conditions.
(1) All of the following dentures are reimbursable with prior authorization only:
(a) Full dentures;
(b) Immediate dentures:
(c) Partial upper and partial lower dentures with conventional clasps and rests; and
(d) Partial upper and partial lower dentures with bar, conventional clasps, and rests.
(2) The Division does not pay for the relining of partial dentures.

(3) The Division does not pay for overdentures, precision attachments, temporary dentures, cusil-type dentures, or other dentures of specialized designs or techniques.
(4) The provider must submit a complete treatment plan and prosthetic history with the request for prior authorization.
(5) As part of the denture fabrication technique, the member must approve the teeth and set-up in wax before the dentures are processed.
(6) The member's identification must be on each denture.
(7) All dentures must be initially inserted and subsequently examined and adjusted by the dentist at reasonable intervals consistent with practice in the community or at the member's request.
(8) The Division pays for replacement of dentures only under certain circumstances (see 130 CMR 420.427(F)). The member is responsible for denture care and maintenance. The member, or those responsible for the member's custodial care, must take all possible steps to prevent the loss of the member's dentures. The provider must inform the member of the Division's policy on replacing dentures and the member's responsibility for denture care.

(B) Denture Treatment Plan and Prosthetic History.
(1) A prosthetic history must include, but is not limited to, the following information, as applicable:
(a) identification of the teeth to be extracted and, for partial dentures, the teeth to be clasped and replaced;
(b) the length of time the member has been without natural teeth;
(c) the age and current status of previous or present dentures;
(d) whether the Division paid for previous or present dentures;
(e) the length of time the member has been without dentures; and
(f) photographs showing the condition of existing dentures and residual ridges, if requested.
(2) If the member still has natural teeth, the provider must submit with the treatment plan a current series of periapical and bitewing X rays of good diagnostic quality, dated and suitably mounted, of all remaining teeth. If the member has no remaining natural teeth, X rays are not required (see 130 CMR 420.423(B)(4)). The fee for full dentures includes payment for all necessary adjustments, including relines, within six months after insertion of the denture. The fee for a partial denture includes payment for all necessary clasps and rests, regardless of the number.

(C) Full Dentures.
(1) Only permanent dentures are reimbursable. When the provider requests initial full dentures following multiple extractions, generally a period of two months must elapse between the time of the extractions and the time the impressions are taken.

(2) Immediate dentures are reimbursable only when the following conditions are met.
(a) These dentures will be the permanent full dentures.
(b) There are no more than six anterior teeth and no more than one posterior tooth to be extracted at the time of insertion of the denture.
(c) Impressions for the immediate dentures were taken after a suitable period of healing in the region where the posterior teeth were extracted.
(d) There is a favorable prognosis for adaptation to the immediate dentures.
(3) Preformed dentures with mounted teeth (that is, teeth that have been set in acrylic prior to the initial impressions) are not reimbursable.
(4) Fabrication of a denture must be specific to the individual member, consisting of the individual positioning of teeth, wax-up of the entire denture body, and conventional laboratory processing.

(D) Partial Dentures.
(1) The Division considers prior-authorization requests for permanent partial-denture construction only if there are fewer than eight sound posterior teeth in good occlusion. The remaining dentition must be sound and have a good prognosis. Existing or planned crowns, bridges, and partial or full dentures, when present, are counted as occluding teeth.
(2) The Division may also consider a request for a permanent partial denture when the member is missing anterior teeth.
(3) The provider must submit to the Division an outline of the design of the permanent denture, including the identity of the teeth to be replaced and the teeth to be clasped, and current periapical and bitewing X rays of the remaining teeth, dated and suitably mounted.
(4) Design of the prosthesis must be as simple as possible, consistent with the basic principles of prosthodontics.
(5) The provider must certify on the appropriate Division-approved form that all carious teeth are functionally restored and that the supporting structures are in good health.
(6) Partial upper and lower dentures with bar are reimbursable.

(E) Dentures for Members in Long-Term-Care Facilities.
(1) Dental services for members in long-term-care facilities must emphasize retention of the existing dentition consistent with the health and comfort of the member. Most persons in long-term-care facilities adapt better to repairs and other adjustments to existing dentures rather than to extractions or new dentures.
(2) Dentures for members in long-term-care facilities require prior authorization. The provider must submit the following information with a prior-authorization request: a detailed statement of the member's level of medical care; a detailed medical history and diagnosis; medical evaluation of assigned diet and assessment of functional nutritional status; a description of the member's capacity to communicate and to cooperate; and a statement that the member has expressed a desire for the dentures. This documentation must be signed by the member's guardian or the facility's director of nursing and a copy must be included in the member's record at the long-term-care facility.

(3) The Division does not authorize payment for dentures unless the Division has determined that the member is capable of adjusting to a prosthesis. The provider must not prescribe dentures without the express consent of the member. Neither the absence of teeth nor cosmetic benefit, alone or in combination, is considered to be a sufficient reason for dentures. In many cases the member is better served with the fabrication of only an upper denture.
(4) The Division reserves the right to request diagnostic photographic prints. (See 130 CMR 420.427(B)(1)(f).)

(F) Replacement of Dentures. The Division pays for necessary replacement of dentures, subject to prior authorization. The Division does not authorize payment for the replacement of dentures if the member's denture history reveals any of the following conditions:
(1) repair or reline will make the existing denture usable;
(2) any of the dentures made previously have been unsatisfactory due to physiological causes that cannot be remedied;
(3) a clinical evaluation suggests that the member will not adjust satisfactorily to the new denture;
(4) no medical or surgical condition in the member necessitates a change in the denture or a requirement for a new denture;
(5) the existing denture is less than seven years old and no other condition in this list applies;
(6) the denture has been relined within the previous two years;
(7) the loss of the denture was not due to extraordinary circumstances such as fire in the home. The request for prior authorization must include documentation, such as a fire report, police report of theft, or photographic prints of broken dentures; or
(8) the member has been edentulous for more than two years, has been functioning satisfactorily without dentures and no significant improvement in the member's health can reasonably be anticipated if the member were to use dentures.

(G) Antidiscrimination Policy. No provider may discriminate against a MassHealth member. If a hospital or nursing facility has a denture-replacement policy in place for other types of insurance carriers and private paying members, the same policy must apply to MassHealth members in the hospital or nursing facility.

(H) Full Denture Relines and Rebases. Payment for all full denture relines and rebases require prior authorization. The Division pays only for full denture relines that are laboratory processed or light cured. "Cold-cure" relines are not reimbursable. The fee for dentures includes payment for any relines necessary within six months of the dispensing date of the denture. Subsequent relines are reimbursable with prior authorization once every two years. More frequent relines require prior authorization and evidence that clinical conditions exist that warrant more frequent relines (for example, a member with head and neck cancer). The request for prior authorization must include a description of the condition of the denture and must fully justify the reason that an additional reline is necessary. If a reline is performed, the Division will not authorize an additional denture for three years for the same member. The Division may require photographic prints of the mouth and existing dentures to support a request for prior authorization.

420.428: Service Descriptions and Limitations: Orthodontic Services — Members Under Age 21

The following service descriptions and limitations apply to orthodontic services provided to members under age 21.

(A) General Requirements. Orthodontic treatment is reimbursable only once per member per lifetime. The provider must begin treatment before a member is 18 years and six months of age so that it is completed before the member reaches age 21. However, the Division will pay for the continuation of full orthodontic treatment as long as the member remains eligible for MassHealth, provided that initial treatment started before the member reached age 18 years and six months. This payment limitation also applies to any pre- or post-orthognathic surgical case.

(B) Prior Authorization.

(1) The provider must obtain prior authorization from the Division for all orthodontic treatment except for orthodontic consultation and retention following orthodontic treatment. The maximum number of reimbursable retention visits (post-treatment stabilization) is five.

(2) In order to initiate a prior-authorization request for orthodontic treatment, a provider must submit diagnostic photographic prints for the Division's review (see 130 CMR 420.423(D)). If the photographic prints do not substantiate the need for treatment, as determined by Division application of the clinical standard described in Appendix D of the *Dental Manual*, the Division either denies the treatment or requests that the provider submit orthodontic models, photographic prints, and X rays. These are reimbursed only when they are requested by the Division.

(a) If the prior-authorization request for treatment is approved based on the documentation submitted, the provider will obtain prior authorization to bill the service described as “initial fabrication and insertion of orthodontic appliance,” which is reimbursable once per member per lifetime and includes reimbursement for records, photographic prints, models, and X rays. Initial fabrication and insertion of orthodontic appliances includes conventional, complete, and comprehensive state-of-the-art orthodontic treatment.

(b) If the prior-authorization request for treatment is denied based on the documentation submitted, the provider will obtain prior authorization to bill the service described as "orthodontic diagnosis and records, models, photographic prints, and X rays."

(c) If the prior-authorization request for treatment is approved based on the documentation submitted, and the member moves or refuses further treatment, the orthodontist may bill the service described as “orthodontic diagnosis and records, models, photographic prints, and X rays,” billable once per member per lifetime. The records or copies of them may be requested by another orthodontist. The Division may reimburse the second orthodontist for records at its discretion only when initial records are invalid or outdated. The orthodontist must retain pre- and post-treatment photographic prints in the member’s dental record for review.

(C) Orthodontic Consultation. The Division reimburses accredited orthodontists for an orthodontic consultation for the purpose of determining the necessity for orthodontic treatment and assessing the appropriate time to commence treatment. This service is limited to members who are less than 18 years and six months of age. An orthodontic consultation is reimbursable as a separate procedure (see 130 CMR 420.413) and only once per six-month period. An orthodontic consultation is not reimbursable as a separate procedure when used in conjunction with ongoing or planned (within six months) orthodontic treatment. The fee for this service does not include X rays, models, or photographic prints, and prior authorization is not required. The Division does not pay for more than one orthodontic consultation or examination on the same date of service.

(D) Orthodontic X Rays. X rays as a separate procedure for orthodontic diagnostic purposes require prior authorization and are reimbursable only for members under the age of 18 years and six months. Cephalometric X rays are to be used in conjunction with orthodontic diagnosis. Payment for X rays in conjunction with orthodontic diagnosis is included in the fees for orthodontic services. Payment is not made for additional X rays from the same or another provider when required for orthodontic diagnosis. The provider must use the service code for orthodontic X rays when billing for a full-mouth series or for panoramic X rays including bitewings.

(E) Interceptive Orthodontic-Treatment Visits. The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion with primary or mixed dentition. Use of this treatment should preclude or minimize the need for any additional orthodontic treatment. The provider must obtain prior authorization for the number of adjustment visits in conjunction with an interceptive appliance.

(F) Space Maintainers. Space maintainers and replacement space maintainers are reimbursable. Although the initial space maintainer does not require a prior authorization, replacement space maintainers do require prior authorization. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. For primary canines, space maintainers prevent midline deviation, loss of arch length and circumference. Premature loss of primary molars also indicates the use of space maintainers to prevent the migration of adjacent teeth. The loss of primary incisors usually does not require the use of a space maintainer. An initial diagnostically acceptable X ray must be maintained in the member's record, demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. The provider must maintain good diagnostic-quality X rays in the members record. For replacement space maintainers, the provider must include an explanation of the reason for requesting the replacement space maintainer with the request for prior authorization. Treatment (adjustment) visits are not reimbursable for passive space maintainers.

(G) Comprehensive Orthodontic Treatment. Comprehensive orthodontic treatment is reimbursable only once per member per lifetime and only when the member has a severe and handicapping malocclusion. The Division determines whether a malocclusion is severe and handicapping based on the clinical standards described in Appendix D of the *Dental Manual*. The permanent dentition must be reasonably complete (usually by age 11).

(1) Reimbursement covers a maximum period of two and one-half years of orthodontic treatment visits. The provider must request prior authorization for initial fabrication and insertion of the orthodontic appliance. Reimbursement for the initial fabrication and insertion of the orthodontic appliance includes payment for retainers. In addition, the provider must request prior authorization separately for each year of treatment (first, second, and, if necessary, first half of the third year).

(2) When requesting prior authorization for the initial fabrication and insertion of the orthodontic appliance and the first year of orthodontic treatment, the provider must submit the following (see the instructions in Subchapter 5 of the *Dental Manual* for obtaining prior authorization forms):

(a) a signed statement on the provider's letterhead that all restorative services have been completed, with diagnostic X rays demonstrating completion of restorative services (see 130 CMR 420.423(A) and (B)), and an evaluation of the anticipated level of member cooperation and hygiene;

(b) seven diagnostic photographic prints, with a minimum size of three inches by three-and-one-half inches, mounted in clear plastic holders, two of which must include frontal and profile facial views and five intraoral views including anterior, left and right lateral views taken at 90 degrees, and occlusal views taken with a mirror;

(c) a completed PAR Index recording form, which provides results of applying the clinical standards described in Appendix D of the *Dental Manual*;

(d) a completed orthodontics prior-authorization form; and

(e) a completed prior-authorization form.

(3) When requesting prior authorization for orthodontic treatment visits subsequent to the first year, for each subsequent year of treatment (the second, and, if necessary, the first half of the third year), the provider must submit the original photographic prints, intraoral progress photographic prints, an updated progress statement for each year of treatment that all restorative services have been completed with diagnostic X rays (see 130 CMR 420.423(A) and (B)), an updated evaluation of anticipated cooperation and hygiene, and a copy of the initially submitted orthodontics prior-authorization form with Part IV completed with progress to date.

(4) Upon the completion of orthodontic treatment, the provider must take photographic prints and maintain them in the member's medical record, subject to review by the Division at its discretion.

(H) Orthodontic Treatment Visits. The provider must request prior authorization for each of the first, second, and, if necessary, first half of the third years of orthodontic treatment visits. The Division pays for ongoing orthodontic treatment visits on a quarterly basis only for members in active orthodontic treatment. The Division considers a member to be in active orthodontic treatment if the member's dental record indicates that orthodontic treatment was provided in the previous 90 days or if the provider includes a justification in the member's dental record for maintaining the member's active status (for example, extended illness). Broken appointments alone do not justify a lapse in service beyond 90 days. If a member becomes inactive for any period of time, prior authorization is not required to resume orthodontic treatment visits and subsequent billing unless the prior-authorization time limit has expired. Orthodontists should see members every four-to-six weeks. However, the Division recognizes that illness or other extenuating circumstances may cause MassHealth members to occasionally miss appointments. Therefore, the Division requires that MassHealth members receive treatment visits in at least eight out of 12 months in an authorized year of treatment before billing for the next treatment year. The Division requires that three treatment units of one quarter each be billed before requesting prior authorization for the second and third year of treatment. The number and dates of visits must be documented in the member's orthodontic record.

(I) Replacement Retainers. The Division pays for a replacement retainer only during the two-year retention period following orthodontic treatment. The provider must obtain prior authorization and include the date of onset of retention with the request for prior authorization.

(J) Retention Visits. The Division pays separately for up to five retention visits following orthodontic treatment. Prior authorization is not required.

(K) Early Appliance Removal. A prior-authorization request for early appliance removal must include documentation of parent or guardian authorization and an explanation from the orthodontist.

(L) Patient Noncooperation. If the provider determines that continued orthodontic treatment is not indicated because of lack of member cooperation, the provider may request individual consideration for appliance removal. At this time, the provider may also request approval for the placement of retainers.

(M) Additional Consultation. The Division may request additional consultation for any orthodontic procedure requiring prior authorization.

(N) Orthodontic Models and Study Models. Orthodontic models and study models are reimbursable as a separate procedure only when requested by the Division as part of a prior-authorization request for treatment procedures and only when the study models are of good diagnostic quality, properly articulated, well trimmed, and poured in white plaster. Payment for orthodontic models is otherwise included in the fees for orthodontic services. Payment will not be made for an orthodontic model as a separate procedure when prior authorization is granted for orthodontic diagnosis or treatment.

420.429: Service Descriptions and Limitations: Exodontic Services — Members Under Age 21

The following service descriptions and limitations apply to exodontic services provided to members under age 21.

(A) General Conditions. Reimbursement for exodontic services includes payment for local anesthesia, suture removal, irrigations, spicule removal, apical curettage of associated cysts and granulomas, enucleation of associated follicles, and routine preoperative and postoperative care. The Division does not pay for routine exodontia provided in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center for exodontia is limited to those members whose health, because of a medical condition, would be at risk if these procedures were performed in the provider's office. Member apprehension alone is not sufficient justification for use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for the administration of general anesthesia when the procedure can be routinely performed with local anesthesia does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Many services listed in Appendix E of the *Dental Manual* are allowed in the office.

(B) Simple Extraction. Simple extraction is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. The removal of root tips whose main retention is soft tissue is considered a simple extraction. All simple extractions may be performed as necessary. The Division may investigate an unusually heavy use of simple extractions in the primary dentition to determine whether such extractions were medically necessary. The Division does not pay for the extraction of deciduous teeth that appear from X-ray evaluation to be near exfoliation. Incision and drainage performed at the time of extraction is not reimbursable as a separate procedure.

(C) Surgical Removal of Erupted Tooth. The Division pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to effect the extraction or the sectioning of a tooth. This may also include root tips if the reviewer determines that retention is more than soft tissue (that is, bone). The provider must maintain a preoperative X ray of the erupted tooth in the member's dental record to substantiate the service performed. The Division determines the necessity of surgical extraction from X rays and clinical documentation in the member's dental record.

(D) Surgical Removal of Impacted Tooth. The Division pays for the surgical removal of an impacted tooth. Surgical removal of an impacted tooth requires prior authorization. When prior authorization is requested for a surgical procedure in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the provider must state the medical necessity and the particular complexity of the procedure that justifies the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Member apprehension alone is not sufficient justification for the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia when the procedure can be routinely performed with local anesthesia does not justify use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(1) Circumstances under which the Division pays for surgical removal of impacted teeth include but are not limited to:

(a) full bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length;
(b) teeth involving a cyst, tumor, or other neoplasm;
(c) unerupted teeth causing the resorption of roots of other teeth;
(d) partially erupted teeth that cause intermittent gingival inflammation; and
(e) perceptive radiologic pathology that fails to elicit symptoms.

(2) Extraction of an unerupted tooth in a follicular stage is not reimbursable.

(3) The provider must maintain a preoperative X ray of the impacted tooth in the member's dental record to substantiate the service performed. The X ray must clearly define the category of impaction. The Division determines the degree of impaction from the X rays and clinical records in the member's dental record.

(4) A root tip is not considered an impacted tooth.

(5) Surgical removal of a whole tooth with soft-tissue impaction is the removal of a tooth in which the occlusal surface of the tooth is covered by soft tissue requiring mucoperiosteal flap evaluation for removal. This service requires prior authorization.

(6) Surgical removal of a whole tooth with partial bony impaction is the removal of a tooth in which part of the crown is covered by bone and requires mucoperiosteal flap elevation and bone excision for removal. Segmentalization of the tooth may be required. This service requires prior authorization.

(7) Surgical removal of a whole tooth with complete bony impaction is the removal of a tooth in which most or all of the crown is covered by bone and requires mucoperiosteal flap elevation, bone removal and possible segmentalization for removal. This service requires prior authorization.

(8) Surgical exposure of impacted teeth requires prior authorization. The procedure is limited to members under 21 years of age for the exposure of impacted canines for orthodontic reasons. The Division may request an orthodontic consultation as a result of the review of the request for prior authorization. The Division does not pay for reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoplasty.

(1) Payment for alveoplasty procedures performed in conjunction with the extraction of teeth is included in the fee for the extraction procedures when six or fewer teeth per jaw are extracted during the same treatment visit.

(2) A provider may claim a separate payment for an alveoplasty only when seven or more teeth per jaw are extracted during the same treatment visit. Edentulous quadrant alveoplasties require prior authorization. The Division pays only once for the same quadrant alveoplasty (dentulous or edentulous) when performed within six months of full or partial denture construction.

(3) The fee for alveoplasty includes payment for tori, tuberosity reductions, and removal of exostoses.

(4) Alveoplasty does not require prior authorization for eligible members.

(F) Frenectomy. Frenectomies may be performed to release tongue ties, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. Frenectomy does not require prior authorization. If the purpose of the frenectomy is to release a tongue tie, a written statement by a physician or primary care clinician and a speech pathologist clearly stating the problem must be maintained in the member's dental record. The Division does not pay for labial frenectomies performed before the eruption of the permanent canines, unless orthodontic documentation that clearly justifies the need for the procedure is maintained in the member's dental record.

(G) Excision of Hyperplastic Tissue. Excision of hyperplastic tissue requires prior authorization. This procedure is for the preprosthetic removal of such lesions as fibrous epuli or benign palatal hyperplasia. The Division may request photographs or models as a result of the review of the request for prior authorization. The photographs and models as well as any related pathology report must be retained in the member's dental record.

(H) Postoperative Visits. Payment for routine postoperative visits is included in the fee for surgical procedures. This includes routine suture removal. Nonroutine postoperative follow-up in the office is an individual-consideration service that is reimbursable only for unusual services and only to ensure the safety and comfort of a postsurgical member. This nonroutine postoperative visit may include drain removal or packing change. A detailed report must be submitted for individual consideration in conjunction with the claim form for postoperative visit. The date, the location of the original surgery, and the type of procedure defines the report.

(130 CMR 420.430 and 420.431 Reserved)

420.432: Service Descriptions and Limitations: Introduction — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Service descriptions and limitations that are specific to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) are set forth in 130 CMR 420.433 through 420.439. Unless otherwise specified below, the service descriptions and limitations for services provided to such members are identical to the coverage for members under age 21 as set forth in 130 CMR 420.422 through 420.429. In addition, services that apply to all members, including members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.433: Service Descriptions and Limitations: Diagnostic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Diagnostic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described in 130 CMR 420.422(A) through (C), except that the only X rays reimbursable with regard to an emergency care visit are those described and limited in 130 CMR 420.434.

420.434: Service Descriptions and Limitations: X Rays — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

X-ray services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.423, except as follows.

(A) Mixed Dentition X Rays. The services described in 130 CMR 420.423(B)(1)(b) are not reimbursable.

(B) Panoramic X Rays. The services described in 130 CMR 420.423(C)(2) are not reimbursable.

(C) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the Division.

420.435: Service Descriptions and Limitations: Preventive Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Preventive services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.424, except as follows.

(A) Fluoride. The services described at 130 CMR 420.424(B)(1) and (2) are not reimbursable. The Division pays for topical fluoride treatment for members who also have medical or dental conditions that significantly interrupt the flow of saliva, subject to prior authorization. The prior-authorization request must include documentation of such conditions that may include, but are not limited to, radiation therapy, tumors, certain drug treatments, such as some psychotropic medication, and certain diseases and injuries.

(B) The services described in 130 CMR 420.424(E) and (F) are not reimbursable.

420.436: Service Descriptions and Limitations: Restorative Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Restorative services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.425, except as follows.

(A) Composite Resin Restorations. The services described in 130 CMR 420.425(B)(4), (6), and (7) are not reimbursable.

(B) Crowns, Posts, and Cores.

(1) The Division pays for crowns on anterior teeth only, subject to the prior-authorization criteria set forth in 130 CMR 420.425(D)(1), (2), (4), (5), (6), and (8). Neither acrylic jacket crowns nor stainless-steel or prefabricated resin crowns for primary molars or permanent molars are reimbursable.

(2) The Division does not pay for crowns for a posterior tooth unless extraction (the alternative treatment) would cause undue medical risk for a member with one or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include but are not limited to

(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.

(C) Fixed Bridgework. The services described in 130 CMR 420.425(E) are not reimbursable.

420.437: Service Descriptions and Limitations: Endodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

The maximum allowable fee for endodontic services includes payment for all X rays performed during the same treatment session. Endodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.426, except as follows.

(A) Pulpotomy. The services described in 130 CMR 420.426(A) are not reimbursable.

(B) Root Canal Therapy.

(1) The Division pays for root-canal therapy on anterior teeth only.

(2) The Division does not pay for root-canal therapy for a posterior tooth unless removable prosthodontics (the alternative treatment) would cause undue medical risk for a member with one or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include but are not limited to

(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.

420.438: Service Descriptions and Limitations: Prosthodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Prosthodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.427, except as follows.

(A) Dentures. The services described in 130 CMR 420.427(A)(1)(b) and (d) are not reimbursable.

(B) Denture Treatment Plan and Prosthetic History. The fee for dentures includes payment for any relines necessary within 12 months after insertion of the denture.

(C) Full Dentures. The services described in 130 CMR 420.427(C)(2) are not reimbursable.

(D) Partial Dentures. The services described in 130 CMR 420.427(D)(6) are not reimbursable.

(E) Full Denture Relines and Rebases. The fee for dentures includes payment for any relines necessary within 12 months of the dispensing date of the denture. Subsequent relines are reimbursable with prior authorization once every three years.

420.439: Service Descriptions and Limitations: Exodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Exodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.429(A) through (H), except that the services described in 130 CMR 420.429(D)(8) are not reimbursable.

(130 CMR 420.440 and 420.441 Reserved)

420.442: Service Descriptions and Limitations: Introduction — Other Members Aged 21 and Older

Service descriptions and limitations that are specific to members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) (other members aged 21 and older) are described in 130 CMR 420.443 through 420.449. In addition, services that apply to all members, including members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.443: Service Descriptions and Limitations: Diagnostic Services —Other Members Aged 21 and Older

Except for emergency dental care, as described and limited in 130 CMR 420.422(C), diagnostic services are not reimbursable when provided to other members aged 21 and older; except that the only X rays reimbursable with regard to an emergency care visit are those described in 130 CMR 420.444.

420.444: Service Descriptions and Limitations: X Rays — Other Members Aged 21 and Older

X-ray services that are reimbursable when provided to other members aged 21 and older consist of the following.

(A) Intraoral X Rays. The Division pays for intraoral X rays as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements.

(1) Full-Mouth X Rays. Full-mouth X rays are reimbursable as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. All other provisions of 130 CMR 420.423(B)(1)(a) apply.

(2) Bitewing Survey. The Division pays for up to two bitewing X rays as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. Bitewing X rays may not be billed separately when taken as part of a full-mouth series.
(3) Periapical X Rays. The Division pays for periapical X rays. A maximum of four periapical X rays may be taken as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a treatment related to prior-authorization requirements. Prior authorization is required for additional X rays.

(B) Panoramic X Rays for Surgical Conditions. The service descriptions and limitations are identical to those set forth in 130 CMR 420.423(C)(1).

(C) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the Division.

420.445: Service Descriptions and Limitations: Preventive Services— Other Members Aged 21 and Older

Preventive services are not reimbursable when provided to other members aged 21 and older, with the exception of the service as described and limited in 130 CMR 420.435(A).

420.446: Service Descriptions and Limitations: Restorative Services — Other Members Aged 21 and Older

Restorative services are not reimbursable when provided to other members aged 21 and older, with the exception of the service as described and limited in 130 CMR 420.449(B).

420.447: Service Descriptions and Limitations: Endodontic Services — Other Members Aged 21 and Older

(A) Endodontic services are not reimbursable when provided to other members aged 21 and older, with the exception of the service described and limited in 130 CMR 420.447(B).

(B) If an extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, the Division will pay for root-canal therapy (the alternative treatment) for a tooth, subject to prior authorization. The prior-authorization request must include documentation of these medical conditions, which include, but are not limited to

(1) hemophilia;
(2) history of radiation therapy;
(3) acquired or congenital immune disorder;
(4) severe physical disabilities such as quadriplegia;
(5) profound mental retardation; and
(6) profound mental illness.

420.448: Service Descriptions and Limitations: Prosthodontic Services — Other Members Aged 21 and Older

Prosthodontic services are not reimbursable when provided to other members aged 21 and older.

420.449: Service Descriptions and Limitations: Exodontic Services — Other Members Aged 21 and Older

(A) Exodontic services that are reimbursable when provided to other members aged 21 and older consist of all services as described and limited in 130 CMR 420.429 (A) through (H), except that the services described in 130 CMR 420.429(D)(8) are not reimbursable.

(B) In addition to the services described in 130 CMR 420.449(A), if an extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, with prior authorization the Division will pay for a crown (the alternative treatment). The prior-authorization request must include documentation of these medical conditions, which include, but are not limited to

(1) hemophilia;
(2) history of radiation therapy;
(3) acquired or congenital immune disorder;
(4) severe physical disabilities such as quadriplegia;
(5) profound mental retardation; and
(6) profound mental illness.

(130 CMR 420.450 Reserved)

420.451: Service Descriptions and Limitations: Introduction — All Members

The service descriptions and limitations that apply to all members without exception are set forth in 130 CMR 420.452 through 420.457.

420.452: Service Descriptions and Limitations: General Anesthesia and IV Sedation — All Members

The following service descriptions and limitations apply to all members.

(A) General anesthesia or IV sedation is reimbursable without prior authorization when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services. All rules, regulations, and requirements set forth by the Massachusetts Board of Registration in Dentistry and by the Massachusetts Society of Oral and Maxillofacial Surgeons that apply to office general anesthesia, intravenous sedation, and the various forms of analgesia must be followed without exception. General anesthesia and IV sedation may only be used for oral surgery and maxillofacial procedures.

(B) The administration of analgesia (orally (PO), rectally (PR), inhalation nitrous oxide (N_2O/O_2)) and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure (see 130 CMR 420.413).

(C) A completed anesthesia flowsheet must be retained in the member's dental record. In addition, the provider must document the following in the member's dental record:

(1) the beginning and ending times of any general anesthesia or analgesia;
(2) preoperative, intraoperative, and postoperative vital signs;
(3) medications administered including their dosages and routes of administration;
(4) monitoring equipment utilized; and
(5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction.

(D) Providers may claim payment for general anesthesia or IV sedation services for the first 30 minutes and then only in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual.* Payment is limited to a maximum of 90 minutes.

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services — All Members

The following service descriptions and limitations apply to oral and maxillofacial surgery services provided to all members. Reimbursement for oral and maxillofacial surgery services is full payment for member care and includes payment for routine inpatient preoperative and postoperative care as well as for any related administrative or supervisory duties in connection with member care.

(A) Introduction. Reimbursable oral and maxillofacial surgery services consist of those basic surgical services essential for the prevention and control of diseases of the oral cavity and supporting structures and for the maintenance of oral health. The Division pays only for those services consistent with the regulations in 130 CMR 420.000. Maxillofacial surgery services are reimbursable only for the purpose of anatomic and functional reconstruction of structures that are missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic benefit may result from such surgical services but cannot be the primary reason for those services.

(B) General Conditions. Only oral surgery specialists may claim payment for the services listed in Appendix E of the *Dental Manual* and only if proper certification is on file at the Division's Provider Enrollment Unit. Oral surgery specialists may also bill for services listed throughout Subchapter 6 of the *Dental Manual*. Prior authorization is required if indicated next to the service description for the oral and maxillofacial surgical service. Services not listed in the *Dental Manual* are not covered by the Division. In no instance does the Division pay for new procedures or materials that are not within the scope of standard clinical practice, nor does it pay for procedures considered experimental. In general, most service codes allow for the delivery in the office location where feasible and considered safe for the member. Most routine dentoalveolar surgery requires prior authorization for hospital admission or treatment except for extractions and dentulous alveoplasties.

(C) Orthognathic Surgery.

(1) Orthognathic surgery requires prior authorization. Requests for prior authorization must include at least the following:

(a) a full dental and surgical treatment plan;
(b) documentation of orthodontic consultation;
(c) full-mouth X rays;
(d) preoperative models;
(e) preoperative cephalometric X ray with tracing;
(f) projected cephalometric analysis; and
(g) photographs of the face and teeth from the AP (anterior and posterior) and lateral projections.

(2) The prior-authorization request must include a complete and precise description of the requested surgical procedures and the necessity of progressive procedures (staging), if anticipated. The request must explain the medical necessity of these procedures. The Division does not pay for orthognathic surgery performed for cosmetic or experimental reasons. Any proposed orthodontic treatment must meet all the criteria described at 130 CMR 420.428.

420. 454: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Procedures — All Members

The following service descriptions and limitations apply to all members. Most oral and maxillofacial surgery codes allow for the office location where technically feasible and safe for the member. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center is mandatory in major maxillofacial surgery such as multiple trauma and orthognathic surgery. The Division pays for the use of such settings when it is justified by the difficulty of the surgery (for example, four deep bony impactions) in addition to the medical health of the member (for example, asthmatic on multiple medications, alcoholism, or drug history, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(A) Utilization Management Program. The Division pays for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.209 are satisfied. Appendix G of the *Dental Manual* contains the name, address, and telephone number of the contact organization for the screening program and describes the information that must be provided as part of the review process.

(B) Surgical Assistants. Payment to surgical assistants is 15 percent of the allowable fee for the procedure performed, with a minimum payment of $20.00.

(C) Preoperative Diagnosis and Postoperative Care. For surgery procedures performed in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the fees include payment for preoperative diagnosis and postoperative care during the member's stay and are the maximum allowable amounts.

(D) Inpatient Visits. The Division pays providers for visits to hospitalized members except for routine preoperative and postoperative care to members who have undergone or who are expected to undergo surgery. Inpatient visits are reimbursable only under exceptional circumstances such as with preoperative or postoperative complications or the need for extended care, prolonged attention, intensive-care services, or consultation services. Prior authorization is not required; however, the provider must substantiate the need for this service in the member's hospital medical record.

(E) Multiple Procedures.

(1) The Division does not pay separately for the component parts of a major, more comprehensive service when they are performed on the same date as the comprehensive service. Payment for a comprehensive service includes any separately identified component parts of the comprehensive service, even when separate service codes exist for the component parts. For example, the provider may not claim payment for a frenectomy performed at the time of a full vestibuloplasty with graft.

(2) Where two or more individual procedures are performed in the same operative session, the procedure with the largest fee-schedule amount is payable at the full amount, and each additional procedure is payable at 50 percent of the amount. This requires the use of modifiers and applies only to numeric service codes listed in Appendix E of the *Dental Manual*.

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics — All Members

The following service descriptions and limitations apply to maxillofacial prosthetic services provided to all members.

(A) Payment for maxillofacial prosthetics is limited to dental practitioners who have completed a training program in maxillofacial prosthetics. Payment for maxillofacial prosthetics requires prior authorization and is reviewed on an individual-consideration basis. The Division approves requests only if the maxillofacial prosthetic device will be constructed for the treatment of a member with congenital, developmental, or acquired defects of the mandible or maxilla and associated structures.

(B) A detailed description of the defect and the proposed device must be submitted with a request for prior authorization and must provide sufficient information and justification for the Division to determine the medical necessity and appropriateness of the device. A photograph of the defect and the device may be required.

(C) The Division pays for opposing appliances only when they are necessary for the balance or retention of the primary maxillofacial prosthetic device.

420.456: Service Descriptions and Limitations: Other Services — All Members

The following service descriptions and limitations apply to all members.

(A) Admission of Members with Certain Disabilities for Restorative, Endodontic, or Exodontic Dentistry.

(1) A severely and persistently mentally ill or physically or developmentally disabled member, under certain circumstances, may undergo restorative, endodontic, or exodontic dental procedures for which they are eligible in a hospital (inpatient or outpatient setting) or in a freestanding ambulatory surgery center. The use of these facilities for restorative, endodontic, or exodontic dentistry requires prior authorization. Use of these facilities may be indicated for a member who

(a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting;
(b) is extraordinarily uncooperative, fearful, or anxious;
(c) is an uncommunicative child or adolescent with dental needs requiring immediate attention;
(d) has dental needs but for which local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or
(e) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting.

(2) Requests for prior authorization of restorative, endodontic, or exodontic services in such settings must include
(a) a detailed description of the member's illness or disability;
(b) a history of previous treatment or attempts at treatment;
(c) a treatment plan listing all procedures and the teeth involved;
(d) X rays (if X rays are not available, an explanation is required);
(e) photographs to indicate the condition of the mouth if X rays are not available; and
(f) documentation that there is no other suitable site of service for the member that would be less costly to the Division.

(3) Ordinary fear, ordinary apprehension, or age alone does not justify admission to a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(B) Oral Screenings for Members Undergoing Radiation Treatment or Chemotherapy.

(1) Members undergoing radiation, chemotherapy, or both, or who are on long-term immunosuppressive therapy may require oral screenings. All oral screenings require prior authorization. Requests for prior authorization must include
(a) a list of all services provided to the member;
(b) a medical diagnosis;
(c) a copy of the referral from the attending physician, primary care clinician, or hospital; and
(d) if the oral screening is performed in a hospital (inpatient or outpatient setting), justification for the use of such a setting.

(2) Oral screenings are reimbursed under a global fee. The global fee for oral screenings includes
(a) comprehensive oral examination;
(b) consultation;
(c) salivary flow measurements;
(d) oral hygiene evaluations and instructions;
(e) fluoride treatments;
(f) construction of fluoride trays;
(g) follow-up examination; and
(h) follow-up salivary evaluations.

420.457: Dental Management of Members with Certain Disabilities in the Office

(A) Payment of an additional fee for management of a severely and persistently mentally ill or physically or developmentally disabled member in the office requires prior authorization. The request for prior authorization must contain:

(1) a clear statement of the member's illness or disability
(2) a history of treatment or previous attempts at treatment;
(3) the types of services to be furnished; and
(4) any anesthetic agents to be used.

(B) For payment of the additional fee for emergency palliative treatment of dental pain, the provider may request prior authorization after the provision of the service, provided that such authorization is requested prior to billing.

(130 CMR 420.458 through 420.460 Reserved)

REGULATORY AUTHORITY

130 CMR 420.000: M.G.L. c. 118E, §§ 7 and 12.

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